

EMDR and Hypnosis in the Treatment of Phobias

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Clinical hypnosis and EMDR have both been employed in the treatment of phobias. EMDR has been a controversial treatment method with the research showing mixed results concerning its efficacy. Many studies have shown the effectiveness of hypnosis in the treatment of phobias, but no studies have directly compared hypnosis to EMDR. This paper discusses each approach to treatment, with special emphasis on EMDR. Relevant research and current theories are reviewed along with questions raised and recommendations for future research.

Clinical hypnosis and EMDR have not found ready acceptance in the medical field although claims of dramatically enhanced treatment results have been made for both. EMDR is defined as a treatment method or method of therapy whereas hypnosis has been defined in many ways and used for many varied purposes. Clinical hypnosis refers to the use of hypnosis as a technique employed as an adjunct to different treatment approaches with differing theoretical bases. Thus, it is somewhat difficult to compare and contrast EMDR and hypnosis. However, the present paper will review how EMDR and hypnosis have been used in the treatment of specific phobias. Hypnosis and EMDR have been used in the treatment of phobias in dissimilar ways, and there have been no studies that compare the efficacy of the two approaches. Thus, the current paper will focus on discussing each separately, and then compare and contrast them in regard to treatment of phobias. Some of the controversies will be discussed along with suggestions for future directions for research.

EMDR

Eye Movement Desensitization and Reprocessing (EMDR) was developed by Francine Shapiro (1989) as a methodology for treating traumatic memories. The therapist would instruct the patient to target a visual image, feeling, bodily sensation, or cognition while the therapist moved her fingers back and forth in such a way that when the patient tracked the movement, the patient's eyes moved rapidly back and forth. Initially, the term was Eye-Movement Desensitization (EMD). Later the model was reconceptualized, and the term was changed to EMDR. A protocol was developed to desensitize negative images, feelings,

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cognitions, and bodily sensations, followed by installation of positive cognitions. Patients were periodically asked to rate their disturbance on a 10-point scale of subjective units of disturbance (SUDS) with higher numbers relating to higher intensity disturbance. Patients were also asked to rate the cognitions in terms of their validity (VoC) on a 7-point Likert scale, with higher numbers representing a stronger degree of validity. Although eye movements are usually involved, other forms of bilateral stimulation have also been used including hand taps and auditory tones. Originally, the technique was thought to involve the concept of reciprocal inhibition (Shapiro, 1989); however, now it is described as an accelerated information processing method (Shapiro, 1995).

Research on EMDR has proliferated in recent years, however, EMDR is so controversial that it is difficult to draw conclusions about its efficacy as a treatment modality. Much of the research has been done looking at the results of EMDR on PTSD. The studies using randomized, controlled trials have included comparisons against a wait-list, comparisons against other treatments, and studies that test the ingredients of EMDR. Shapiro in 1998 cited thirteen controlled studies; six that demonstrated superiority of EMDR over placebo or alternative treatments, and two studies that found EMDR to be more effective than a wait-list control. Stickgold, Smyth, and Foster (1999) and Smyth, de Jongh, Greenwald, Reves, and Rogers (1999) review many other studies including those done with children and adolescents as well as adults, and focusing on PTSD, phobias, panic disorders, public speaking anxiety, test anxiety, and antisocial behavior. The EMDR web site lists many other controlled studies, yet most review articles mention only a few, and tend to emphasize those which show that EMDR achieves the same results as other cognitive behavioral exposure techniques (Muris, Merckelbach, Holdrinet, & Sijsenaar, 1998; Carrigan & Levis, 1999; Devilly & Spence, 1999).

In particular, a series of articles has been highly critical of the claims of EMDR proponents, such as the articles by Lohr, McNally, Rosen, and their colleagues (Lohr, Kleinecht, Tolin, & Barret, 1995; Lohr, Tolin, & Lilienfeld, 1998; McNally, 1999; Rosen, Lohr, McNally & Herbert, 1998; Rosen, McNally, Lohr et al., 1998). These articles have been critical of the research done by EMDR proponents, and claim to find no evidence for the relevance of the eye movements or other forms of bilateral stimulation to the treatment outcomes obtained with the EMDR protocols. These authors view EMDR as a combination of the cognitive-behavioral techniques of imaginal exposure and cognitive restructuring.

Shapiro (1998) and other proponents of EMDR have responded to the critics by emphasizing flaws in the research including: lack of fidelity to the 8-stage EMDR protocol; the use of inadequately trained EMDR clinicians in the studies; studies with small samples and brief treatments; failure to prove that eye movement does not enhance imaginal exposure (Rosen & Lohr, 1997); and methodological flaws in the component analyses studies (Shapiro, 1998). Rosen (in press) has responded by claiming that the EMDR proponents misunderstand and misuse the treatment fidelity concept. The controversy continues unabated.

EMDR in the treatment of phobias

Phobias are considered to be anxiety disorders where a particular stimulus elicits a fear response. The fear is usually excessive and cued by the presence or anticipation of specific objects or situations. The person knows that the fear is unreasonable, but the distress is so great that avoidance is the only response, and avoidance has the potential of significantly interfering with the person's functioning in daily life. The fear is acquired through trauma or observing trauma, and learned through the classical conditioning paradigm. The DSM-IV manual lists agoraphobia, specific phobia, and social phobia. Specific phobias include animal type, natural environmental type, blood-injection-injury type, situational type, and

other type. Other investigators such as Ad de Jongh (1999) have classified specific phobias into three categories: (1) situations in the natural environment; (2) animals; and (3) mutilation, which includes medical situations, blood, injuries, and injections. These are very similar categories to those in DSM-IV, merely combining natural environment and situation categories. Crawford and Barabasz (1993) categorize phobias as fears of interpersonal events; fears associated with death, physical pain, and surgery; fears of animals and insects; and fears of environmental concerns. These categories are also similar to those of de Jongh (1999) with the addition of a separate category for interpersonal events.

Crawford and Barabasz (1993) in their review of treatment of phobias mention numerous treatment interventions emphasizing imagery. These include behavioral techniques such as systematic desensitization, cognitive desensitization, emotive imagery, and flooding, and psychodynamic approaches involving uncovering, abreaction, and insight. Psychodynamic strategies use imagery to discover symbolic meaning and etiology of the phobias, while the behavioral and cognitive strategies focus on how phobias are learned and can be unlearned.

Many studies have been done on animal phobias and some on environmental situations, in particular, phobias of spiders, snakes, injections, heights, and flying. A typical treatment involves the cognitive-behavioral intervention of in vivo exposure. For example, with spider phobias, subjects are exposed to spiders and encouraged to let the spiders walk on their hands. Spiders of increasingly larger sizes are used. As the subjects experience that they can be exposed to spiders without being bitten or contaminated, their fear is reduced. Exposure techniques are effective with these kinds of phobias.

However, studies have not been done nor could they be done, on the use of exposure techniques with phobias which have a large traumatic component such as auto accidents, choking, bee or wasp stings, dog bites, etc. In fact, many phobias are not learned through classical conditioning. Most people do not get bitten by snakes, fall from high places, or experience airplane crashes, and it is the *anticipation* of these events that becomes the fearful situations. Ad de Jongh (1999) cites statistics showing that particular phobias such as those involving dogs, blood, injuries, injections, choking, public speaking, and dental phobias usually have a traumatic basis in experience. De Jongh (1999) claims that these kinds of phobias do not respond well to exposure treatment, and exposure may result in retraumatization.

Ad de Jongh has adapted the EMDR protocol for phobias described by Young (1994), and has developed a protocol for processing the first time frightening experience, then a representative frightening experience, and thirdly, current triggers (de Jongh et al., 1999). He believes it is very important to install a future image of being in the situation and doing well accompanied by a strong positive cognition such as, "I'm in control" or "I can cope." Then he has his subjects visualize the whole process from beginning to end as an imagined videotape of the phobic experience while focusing on the empowering positive cognition. If any distress occurs, it is processed with eye movements or bilateral stimulation until the fear is reduced. He also has his subjects do behavioral exercises where they gradually confront similar situations to prepare for future confrontation with the feared object or situation. His work with dental phobic patients suggests that EMDR is considerably more effective, efficient, and comfortable for the patient than exposure techniques whenever traumatic experiences are involved.

Hypnosis in the treatment of phobias

Crawford and Barabasz (1993) have reviewed the treatment of phobias with hypnosis alone or as an adjunct to cognitive therapy, behavior therapy, and insight therapy. The authors

state that therapeutic approaches that emphasize imagery have been demonstrated to be effective (Habeck & Sheikh, 1984; Kluff, 1986; McGuinness, 1984). Hypnosis has been used as the focused attentional method with cognitive-behavioral therapy or psychodynamic treatment (Crawford & Barabasz, 1993). Use of these treatments along with the introduction of hypnosis with moderately or highly hypnotizable individuals can produce a state in which the patient is more relaxed or focused. Suggestions can reduce the affective or neurophysiological responses of these patients to the phobia-producing stimuli. Desensitization, in particular, relies on visual imagery produced while experiencing a relaxed state. Wolpe and Lazarus (1966) reported that desensitization was performed under hypnosis in approximately one third of their cases.

In addition, hypnosis has been used in combination with cognitive restructuring, in vivo exposure, flooding, and implosion techniques to facilitate extinction of the phobic response (Crawford & Barabasz, 1993). Hypnosis has often been used for guided imagery, image rehearsal, age regression to early memories, and to present suggestions for cognitive restructuring. Kirsch, Montgomery, and Sapperstein (1995) looked at eighteen studies in which cognitive-behavioral therapy had been used with and without hypnosis, and performed a meta-analysis. They reported that the clients who had received cognitive-behavioral treatment with hypnosis showed a 70% greater improvement than clients who had received cognitive-behavioral treatment without hypnosis. Crawford and Barabasz (1993) emphasize that adequate hypnotic capability, measured with standard measures of hypnotizability, is essential to treatment success when hypnosis is used.

Crawford and Barabasz (1993) review the research that provides support or refutation for the idea that certain cognitive abilities, such as vivid imagery and absorptive skills, that are involved in the development of hypnotic responsiveness, are also involved in the development of fears and phobias. Individuals who can imagine the fear-producing stimuli with more intensity and involvement can result in the fear becoming so intense that it produces a phobia. Many studies have shown a relationship between high hypnotizability and the presence of phobias although some studies have shown no relationship. Only one of the studies considered gender, which is surprising given that many more women than men report having phobias and seeking treatment for them.

The American Journal of Clinical Hypnosis, 1981, volume 23 number 4, was a special issue devoted to articles on the use of hypnosis for treatment of phobias. The articles covered the treatments of fear of flying, fear of bovine sounds, penetration phobia, phobia of slugs, snake phobia, contamination phobia with hand washing, and phobia of dead birds. The treatment methods described varied considerably including systematic desensitization with hypnosis, hypnotic dream elicitation, age regression, imagery, hypnosis combined with flooding, and hypnosis combined with a problem restructuring strategy. Some of the results reported were dramatic, including the finding that hypnotizable patients were over two and one half times more likely to report positive treatment results than those found to be nonhypnotizable on the Hypnotic Induction Profile (Spiegel, Frischholz, Maruffi, & Spiegel, 1981).

It is apparent in exploring the use of hypnosis in the treatment of phobias, that hypnosis is used as an adjunct to other treatment methods whether they are cognitive-behavioral or more psychodynamic in nature. In contrast, EMDR is currently viewed as a method of psychotherapy in itself, and not as an adjunct to other modes of psychotherapy. This difference may contribute to why EMDR is under such attack, and also why it can be compared to other forms of treatment more easily than hypnotic treatment methods can be compared to other treatment methods. These issues will be discussed in more detail below.

Theories and Research

How are EMDR and hypnosis similar or different? How do they work? What are the advantages and disadvantages of each? These are questions that would be answered differently depending on whether one is a clinician or researcher. There have been no research studies clearly contrasting EMDR versus hypnosis although many of the studies comparing EMDR and cognitive-behavioral techniques include components of hypnosis, i.e. relaxation, imagery, eye-fixation etc., such that it is very difficult to tease out the effects of cognitive-behavioral interventions from these components of clinical hypnosis.

In the past, EMDR proponents would often state that EMDR shows different brain wave patterns than hypnosis, and is thereby different phenomena. Nicosia (1995) reported on three subjects where EEGs were recorded during both the eye movement and other periods of EMDR. All EEGs were within the normal range, and did not differ significantly from the EEG's obtained during the normal waking state. Nicosia contrasted those results to past studies of EEGs of hypnotized subjects that show EEGs with increased theta, hemispheric asymmetries in beta, or predominance of alpha which also differ between high and low hypnotizable subjects. He interpreted these findings as indicating that hypnotized subjects experience an altered state of consciousness differing significantly from the normal waking state, while subjects in EMDR therapy do not. However, this study needs to be replicated with a much larger sample size. It also would be important to compare subjects in an EMDR condition to subjects hypnotized in an awake-alert trance to see if the same differences would be revealed. It is the opinion of this writer that this one EEG study does not provide conclusive evidence of differences in the state of consciousness between individuals experiencing hypnosis versus EMDR.

Turning from the laboratory to the therapist's office, there are interesting trance-like behaviors that can be observed when a patient is experiencing EMDR therapy. It appears that the patient is in trance in the sense that the patient often becomes immobile except for the eye movements and speech. The range of attention is definitely narrowed and focused. The patient often has increased access to imagery and experiences a flow of associations, similar to hypnotic phenomena. The kind of confabulation that can occur with hypnotically retrieved memories can and does occur with EMDR as well. This is only one example of where collaboration between clinicians and researchers would be important to determine what aspects of the hypnotic situation and the EMDR situation are similar and what are different.

Some researchers who are also clinicians (Stickgold, et al , 1999; Smyth et al., 1999) have emphasized that process research needs to be done where we look at how the EMDR process unfolds in treatment sessions, as well as studies that look at the component parts of the process. For example, in treatment outcome studies, EMDR is often compared to exposure techniques, but they are not the same when looked at in terms of what happens in the clinical setting. Exposure sessions often take a long time, and the subject moves from less fearful stimuli or situations toward those more fearful. In an EMDR session, the subject may begin with the most frightening stimulus as the focal target. Thus, what happens in the treatment process itself may be quite different although outcome research has often found no differences between exposure techniques and EMDR (Smyth et al., 1999).

Rogers (Smyth et al., 1999) discusses the state of component analysis research in EMDR. There are three types of components research: (1) dismantling studies which compare EMDR with an analogue in which one element is removed; (2) studies that investigate one element of the EMDR protocol; and (3) studies comparing different treatments to each other. Rogers reviewed fourteen studies involving eye movements and concluded that methodological

problems prevented any clear conclusions. Some of the studies had EMDR-trained therapists, and some did not. Different protocols for EMDR treatment were used, some barely resembling the standard EMDR protocol. In several of these studies, the non-EMDR group involved a gaze-fixation condition, which Rogers argues is a more demanding task than that of following the therapist's fingers characteristic of EMDR. In the fourteen studies reviewed by Rogers (Smyth et al., 1999), seven showed some effect in the eye movement group with subjective measures, and seven showed no effects from inclusion of the eye movements. Rogers implied that many of the studies suffered from problems of small sample size, too-brief treatment, and inappropriate analogs (such as the gaze-fixation condition). Smyth et al. (1999) made the point that randomly assigning subjects to treatment conditions may wipe out main effects that could show up if subjects were matched to conditions. For example, subjects with severe PTSD may benefit from certain treatment conditions that those subjects with less severe PTSD might not. In regard to treatment of phobias in particular, it is recognized that exposure techniques and EMDR often achieve similar results. The main advantages of EMDR appear to be efficiency and comfort, i.e. results are achieved in fewer sessions with EMDR than with exposure techniques, and EMDR is more comfortable for the patient (de Jongh, 1999).

The EMDR research, in general, tends to show that EMDR reduces SUDS level. However, reliance on verbal self-report alone is not considered to be good outcome research (Foa & Meadows, 1997). All the writers tend to agree that the definitive studies contrasting EMDR and the same protocol without the eye movements or other bilateral stimulation have yet to be done. There is general agreement that research is needed which compares EMDR to other treatment methods where the sample size is large; the therapists are well-trained; a neutral assessor does pre and post tests; validated outcome measures are used in addition to self-report; adequate follow-up is reported; and investigation of the actual treatment process is done. We need to know under what conditions does EMDR work, with what kind of patients, what diagnoses, and how the changes occur.

A number of different theories have been advanced as to how EMDR works. Some of the most interesting research has involved exploration of what is happening in the brain. Stickgold (Stickgold et al., 1999), a sleep and dream researcher, believes that trauma interferes with the normal processing of memories that occurs during REM and NREM periods of sleep and dreaming, and that EMDR can restore the process. Nicosia (1994), based on EEG studies of EMDR patients, hypothesized that EMDR resynchronizes the activity of the two hemispheres. Van der Kolk et al. (1997), utilizing single photon emission computerized tomography (SPECT), performed scans before and after EMDR treatment. He showed that after three EMDR sessions, activity increased in the anterior cortex of the cingulate gyrus and in Broca's area in the left prefrontal lobe. These studies are interesting but were performed on a few subjects without control groups, and need to be replicated. Bergmann (1998) in reviewing these studies advanced the hypotheses that: (1) EMDR does appear to correct asymmetry in lateralization; (2) Lateralization may be further corrected by increased bilateral activation of the anterior cingulate cortex, allowing for more realistic differentiation between real and perceived threat with reduction in hypervigilance; and (3) EMDR processing enables the capacity of higher brain functions to override the input from the limbic structures involved with the initial appraisal of the degree of threat. However, Bergmann (1998) admits that the mechanisms of EMDR are as yet unknown.

Other theories of EMDR have evolved from the clinical experience of working with patients using EMDR. The initial explanatory theory of reciprocal inhibition has given way to the idea of accelerated information processing (Shapiro, 1995). Rogers (Smyth et al., 1999)

stated that the eye movements disrupt the intensity of the visual images which decreases their vividness and so decreases emotionality. However, this explanation does not hold up as well when other methods of bilateral stimulation are used, such as tones or hand tapping. Another explanation is that the eye movements provide distraction from the fearful stimulus, and that this split in attention allows for the desensitization effect (Smyth et al., 1999). Renfrey and Spates (1994) argue that distraction could be achieved through other procedures such as fixed visual attention, alternating tones, or other means. Other hypotheses cited by Renfrey and Spates (1994) are that whatever is attended to during EMDR can serve as “safety signals” for the patient because the therapist keeps the exposure period within the patient’s limits for anxiety arousal, decreasing the patient’s anticipated distress and reducing avoidance of the traumatic stimuli. The patient can then bring more objectivity to bear on the situation.

It is the view of the current writer that some of the ingredients of self-hypnosis such as the concepts of ego activity and ego receptivity (Fromm & Kahn, 1990) could apply to EMDR. The patient who is experiencing EMDR uses the mode of ego activity to follow directions which involve moving the eyes and following the therapists fingers. At the same time, ego receptivity is involved in experiencing the flow of images and associations and allowing preconscious material to emerge. Fromm & Kahn (1990) believe that the self-hypnosis experience is heightened by the alternation of ego activity and ego receptivity. In contrast with EMDR, these modes are occurring almost simultaneously, which may also be an explanation for the trance-like behavior that is observed in a patient during EMDR. We could speculate that those patients who are highly hypnotizable may also be able to benefit from EMDR.

Wachtel (1999) in discussing EMDR and psychoanalysis has emphasized that EMDR has more in common with cognitive-behavioral treatment interventions than with psychodynamic approaches, however, he believes that EMDR can be applied in a modified, more free-form fashion to work with patients with characterological issues and relationship problems. He has observed, as has the present writer, that EMDR definitely facilitates the process of free association. He encourages the use of EMDR for exploring a patient’s defense mechanisms, resistances, conflicts, transference, and countertransference, as well as focusing on specific disorders. Wachtel alternates between using EMDR and talking with the patient about the material that emerges. He believes that EMDR is especially useful in the working through process of psychotherapy involving interpretation and reframing (Wachtel, 1999).

In summary, the available evidence suggests that EMDR is a powerful therapeutic tool, when applied appropriately. The evidence for its effectiveness with PTSD and treatment of phobias is particularly compelling. Many aspects of cognitive-behavioral treatments involve ingredients of clinical hypnosis, however studies comparing EMDR specifically to clinical hypnosis have not been reported. In clinical practice, choosing the appropriate method of intervention depends on many factors. In the treatment of phobias, EMDR may be more efficient than other approaches when the phobia is trauma-based.

Often patients have some familiarity with either EMDR or hypnosis and are motivated to try one or the other. EMDR has the disadvantage of being relatively new on the scene, and so has not yet acquired the body of research necessary to establish its acceptance. At this point in time psychotherapists need to familiarize themselves with the literature on both EMDR and hypnosis, and decide which approach is best for that particular patient. Clinicians can be flexible and use both approaches when appropriate. For example, a phobic patient may benefit from learning self-hypnosis for relaxation to use between EMDR sessions. EMDR might be used for processing a trauma while hypnosis is used for ego-strengthening.

The possibilities are limitless and depend on the characteristics of the patient and the imagination of the therapist. The following case study illustrates one way in which hypnosis and EMDR were used in combination to deal with a phobia of driving across bridges.

Case Study

Sharon is a 33-year-old Caucasian woman who specifically wanted treatment with EMDR for her phobias of driving on the freeway and driving over bridges. She had been in psychotherapy with another therapist for twelve years with little change, and felt she wanted to try something different. She had heard about EMDR and thought it might be helpful for her phobias. Following history taking and discussion of treatment methods over several subsequent sessions, we decided that EMDR and hypnosis might both be appropriate. We started with EMDR, beginning with installing a Safe Place. The image that came up for her was sleeping with her cat. We then targeted the earliest memories she had about her fears of driving on freeways and over bridges. Several negative cognitions were identified including, “Bad things always happen to me,” “My world is not safe,” and “I feel incompetent about the way I conduct my life.” Her goal was clear, to be able to drive on freeways and across bridges, and she wanted to feel like a competent person. Living and working in the San Francisco Bay area involves dealing frequently with bridges that are high up over the bay and ranging from three miles to eight miles in length. She lives in the east bay area and for many years has not crossed a bridge to go to San Francisco except when she was with her husband and he was driving. Even then she would feel highly anxious. Her earliest memories, which were targeted and processed, were of panic attacks she had while driving. The anticipation of crossing a bridge brought up feelings of panic and uncomfortable body sensations. Her hands, legs, and feet would feel heavy and cold and her heart would beat rapidly. She sometimes felt dizzy as if she would faint. Her eyes often hurt; she often woke up at night feeling anxious; and she suffered from nightmares. The images in her mind were of losing control of the car and “flying off into space.”

Initially, the earliest memories she could retrieve during EMDR sweeps were of incidents that happened when she was young where she was frequently punished by her father and felt unsafe in her own home. She next recalled experiences in college when she experimented with hallucinogenic drugs and had some frightening driving experiences. Then while experiencing EMDR she remembered an incident from her childhood, where she was a passenger in the back seat of the family car. Her father was driving fast and recklessly as they were going down a hill in San Francisco. Her sister was in the front seat of the car. Sharon remembered the front door on the passenger side flying open and her sister flying out of the car. Although her sister survived, she was badly injured, and Sharon could vividly recall the image of her sister lying in the street covered with blood. These images were processed to the point where Sharon could say convincingly that she knew she was a safe driver, did not speed, and always wore her seat belt. The body scan indicated many familiar uncomfortable body sensations, which were processed until she felt calm and relaxed. She was helped by focusing on going to her Safe Place during a series of eye movement sweeps.

After each of our sessions Sharon would report that she had done more driving, had gone farther than before, and had driven on the freeways, but had not yet been able to drive across a major bridge. The EMDR sessions all were helpful in reducing anxiety symptoms and panic attacks. Night wakening, nightmares, and somatic symptoms all decreased significantly. She was preparing to go on an extended vacation where she and her husband would be doing considerable driving, and she was apprehensive. We decided to utilize hypnosis and systematic desensitization. First we discussed hypnosis and she experienced hypnosis for relaxation. She was able to enter trance easily and found it to be a pleasant

experience. At the next session we composed a hierarchy of situations leading to driving across a bridge. After a hypnotic induction involving focusing on her breathing and muscle relaxation, the situations were presented consecutively using imagery combined with suggestions for relaxation and ego-strengthening suggestions. By the end of the session she reported feeling much more calm and confident. Three weeks later she returned from her vacation and enthusiastically reported that she had driven extensively on her vacation including driving across several bridges. She said she didn't know whether it was the hypnosis or the EMDR or both, but she was feeling very pleased with herself and much more optimistic about the future.

In this case, the combination of EMDR and hypnosis facilitated a positive treatment outcome. We started with EMDR because the patient was familiar with it and had positive expectations. We utilized EMDR for eight, 50 minute sessions and uncovered a number of traumatic experiences which all related to driving, bridges, and feeling unsafe in her world. The visual, cognitive, behavioral, and sensory aspects of each memory were processed with eye movement sweeps. We ended each session with installation of positive cognitions involving a sense of competence in present time and expectations of mastery in the future. However, driving across bridges continued to be the most fearful for her because it contained elements of all her other fears. Hypnosis was chosen as an intervention because of the relaxation phenomena and the opportunity to provide future positive projections and mental rehearsal in imagery of mastery behavior while remaining in a relaxed state.

The success of the hypnotic approach was undoubtedly influenced by the positive therapeutic relationship that had developed during the earlier sessions along with the judicious use of ego-strengthening cognitive interweaves. It is possible that EMDR might have achieved the same results through using the EMDR methods of Resource Installation developed by Leeds (1998). Leeds work has emphasized the importance of establishing imagery with EMDR of positive resources the patient can draw upon before and during the processing of traumatic memories. Ad de Jongh's (de Jongh et al., 1999) method of installing future images with positive cognitions might also have been helpful. However, with this patient, as with other phobia patients who are so fearful of losing control, it seemed particularly useful to utilize systematic desensitization wherein a hierarchy of fearful experiences could be presented during relaxation, beginning with the least fearful and slowly approaching each more fearful imagined event. I believe this helped her to feel more control in the situation as she could gradually imagine doing more driving, approaching a bridge, and then driving over a bridge while continuing to feel relaxed. Hypnosis allows for "sneaking up" on a fearful situation in a controlled manner, whereas at times EMDR can activate more anxiety by targeting a fearful situation if the patient hasn't yet developed resources for calming and strengthening.

The establishment of safety for the patient is a primary concern with both hypnosis and EMDR. Safety was developed in this case with EMDR through the installation of the Safe Place, and the experience of being able to focus directly on frightening material for brief periods of time in the context of the holding environment of the therapeutic relationship. The present writer concurs with Renfrey and Spates (1994) that the attention to eye movements or other bilateral stimulation helps the patient to focus on the fearful stimuli. Then both ego receptivity and ego activity can occur (Fromm & Kahn, 1990). In the case above, because the EMDR experience preceded hypnosis, the feeling of safety had already been established and generalized to the hypnosis experience.

In the present case, EMDR was very helpful in targeting and processing the earlier memories that were trauma-based and had served to reinforce her present fears. It might be argued

that the same results could have been achieved by using hypnotic age regression techniques followed by hypnotic interventions for renegotiation and integration. However, we don't know whether the same traumas would emerge using age regression as did emerge during the enhanced associative process that occurs rapidly during EMDR processing. These are questions that would be very interesting for further exploration.

In conclusion, it is the present writer's opinion that both EMDR and hypnosis are powerful and useful clinical interventions and can have a synergistic effect when used in combination with each other. The choice of which kind of intervention to use at what time depends on the idiosyncrasies of the specific patient and the nature of the therapeutic relationship. Until more is known about the process of EMDR, clinicians need to pay close attention to the presenting symptoms, diagnosis, mental status, ego strength, and access to internal and external resources. More specific guidelines await future research.

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